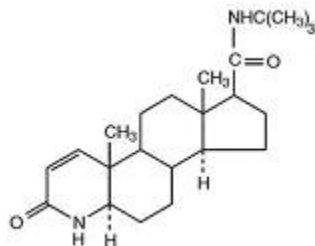


FINASTERIDE - finasteride tablet, film coated
Teva Pharmaceuticals USA

DESCRIPTION

Finasteride, a synthetic 4-azasteroid compound, is a specific inhibitor of steroid Type II 5 α -reductase, an intracellular enzyme that converts the androgen testosterone into 5 α -dihydrotestosterone (DHT).

Finasteride is 4-azaandrost-1-ene-17-carboxamide, *N*-(1,1-dimethylethyl)-3-oxo-, (5 α ,17 β)-. Its structural formula is:



C₂₃H₃₆N₂O₂ M.W. 372.55

Finasteride is a white crystalline powder with a melting point near 250°C. It is freely soluble in chloroform and in lower alcohol solvents, but is practically insoluble in water.

Finasteride tablets for oral administration are film-coated tablets that contain 5 mg of finasteride and the following inactive ingredients: hypromellose, indigo carmine aluminum lake FD&C Blue No. 2, lactose monohydrate, magnesium stearate, microcrystalline cellulose, polyethylene glycol, povidone, pregelatinized starch, sodium lauryl sulphate, sodium starch glycolate, and titanium dioxide.

CLINICAL PHARMACOLOGY

The development and enlargement of the prostate gland is dependent on the potent androgen, 5 α -dihydrotestosterone (DHT). Type II 5 α -reductase metabolizes testosterone to DHT in the prostate gland, liver and skin. DHT induces androgenic effects by binding to androgen receptors in the cell nuclei of these organs.

Finasteride is a competitive and specific inhibitor of Type II 5 α -reductase with which it slowly forms a stable enzyme complex. Turnover from this complex is extremely slow ($t_{1/2}$ ~ 30 days). This has been demonstrated both *in vivo* and *in vitro*. Finasteride has no affinity for the androgen receptor. In man, the 5 α -reduced steroid metabolites in blood and urine are decreased after administration of finasteride.

In man, a single 5 mg oral dose of finasteride produces a rapid reduction in serum DHT concentration, with the maximum effect observed 8 hours after the first dose. The suppression of DHT is maintained throughout the 24 hour dosing interval and with continued treatment. Daily dosing of finasteride at 5 mg/day for up to 4 years has been shown to reduce the serum DHT concentration by approximately 70%. The median circulating level of testosterone increased by approximately 10 to 20% but remained within the physiologic range.

Adult males with genetically inherited Type II 5 α -reductase deficiency also have decreased levels of DHT. Except for the associated urogenital defects present at birth, no other clinical abnormalities related to Type II 5 α -reductase deficiency have been observed in these individuals. These individuals have a small prostate gland throughout life and do not develop BPH.

In patients with BPH treated with finasteride (1 to 100 mg/day) for 7 to 10 days prior to prostatectomy, an approximate 80% lower DHT content was measured in prostatic tissue removed at surgery, compared to placebo; testosterone tissue concentration was increased up to 10 times over pretreatment levels, relative to placebo. Intraprostatic content of prostate-specific antigen (PSA) was also decreased.

In healthy male volunteers treated with finasteride for 14 days, discontinuation of therapy resulted in a return of DHT levels to pretreatment levels in approximately 2 weeks. In patients treated for three months, prostate volume, which declined by approximately 20%, returned to close to baseline value after approximately three months of discontinuation of therapy.

Pharmacokinetics

Absorption

In a study of 15 healthy young subjects, the mean bioavailability of finasteride 5 mg tablets was 63% (range 34 to 108%), based on the ratio of area under the curve (AUC) relative to an intravenous (IV) reference dose. Maximum finasteride plasma concentration averaged 37 ng/mL (range, 27 to 49 ng/mL) and was reached 1 to 2 hours postdose. Bioavailability of finasteride was not affected by food.

Distribution

Mean steady-state volume of distribution was 76 liters (range, 44 to 96 liters). Approximately 90% of circulating finasteride is bound to plasma proteins. There is a slow accumulation phase for finasteride after multiple dosing. After dosing with 5 mg/day of finasteride

for 17 days, plasma concentrations of finasteride were 47 and 54% higher than after the first dose in men 45 to 60 years old (n = 12) and ≥ 70 years old (n = 12), respectively. Mean trough concentrations after 17 days of dosing were 6.2 ng/mL (range, 2.4 to 9.8 ng/mL) and 8.1 ng/mL (range, 1.8 to 19.7 ng/mL), respectively, in the two age groups. Although steady state was not reached in this study, mean trough plasma concentration in another study in patients with BPH (mean age, 65 years) receiving 5 mg/day was 9.4 ng/mL (range, 7.1 to 13.3 ng/mL; n = 22) after over a year of dosing.

Finasteride has been shown to cross the blood brain barrier but does not appear to distribute preferentially to the CSF.

In 2 studies of healthy subjects (n = 69) receiving finasteride 5 mg/day for 6 to 24 weeks, finasteride concentrations in semen ranged from undetectable (< 0.1 ng/mL) to 10.54 ng/mL. In an earlier study using a less sensitive assay, finasteride concentrations in the semen of 16 subjects receiving finasteride 5 mg/day ranged from undetectable (< 1.0 ng/mL) to 21 ng/mL. Thus, based on a 5 mL ejaculate volume, the amount of finasteride in semen was estimated to be 50 to 100 fold less than the dose of finasteride (5 mcg) that had no effect on circulating DHT levels in men (see also **PRECAUTIONS, Pregnancy**).

Metabolism

Finasteride is extensively metabolized in the liver, primarily via the cytochrome P450 3A4 enzyme subfamily. Two metabolites, the t-butyl side chain monohydroxylated and monocarboxylic acid metabolites, have been identified that possess no more than 20% of the 5α-reductase inhibitory activity of finasteride.

Excretion

In healthy young subjects (n = 15), mean plasma clearance of finasteride was 165 mL/min (range, 70 to 279 mL/min) and mean elimination half-life in plasma was 6 hours (range, 3 to 16 hours). Following an oral dose of ¹⁴C-finasteride in man (n = 6), a mean of 39% (range, 32 to 46%) of the dose was excreted in the urine in the form of metabolites; 57% (range, 51 to 64%) was excreted in the feces.

The mean terminal half-life of finasteride in subjects ≥ 70 years of age was approximately 8 hours (range, 6 to 15 hours; n = 12), compared with 6 hours (range, 4 to 12 hours; n = 12) in subjects 45 to 60 years of age. As a result, mean AUC_(0-24 hr) after 17 days of dosing was 15% higher in subjects ≥ 70 years of age than in subjects 45 to 60 years of age (p = 0.02).

Special Populations

Pediatric

Finasteride pharmacokinetics have not been investigated in patients < 18 years of age.

Gender

Finasteride pharmacokinetics in women are not available.

Geriatric

No dosage adjustment is necessary in the elderly. Although the elimination rate of finasteride is decreased in the elderly, these findings are of no clinical significance. See also **Pharmacokinetics**, Excretion, **PRECAUTIONS, Geriatric Use** and **DOSAGE AND ADMINISTRATION**.

Race

The effect of race on finasteride pharmacokinetics has not been studied.

Renal insufficiency

No dosage adjustment is necessary in patients with renal insufficiency. In patients with chronic renal impairment, with creatinine clearances ranging from 9.0 to 55 mL/min, AUC, maximum plasma concentration, half-life, and protein binding after a single dose of ¹⁴C-finasteride were similar to values obtained in healthy volunteers. Urinary excretion of metabolites was decreased in patients with renal impairment. This decrease was associated with an increase in fecal excretion of metabolites. Plasma concentrations of metabolites were significantly higher in patients with renal impairment (based on a 60% increase in total radioactivity AUC). However, finasteride has been well tolerated in BPH patients with normal renal function receiving up to 80 mg/day for 12 weeks, where exposure of these patients to metabolites would presumably be much greater.

Hepatic insufficiency

The effect of hepatic insufficiency on finasteride pharmacokinetics has not been studied. Caution should be used in the administration of finasteride in those patients with liver function abnormalities, as finasteride is metabolized extensively in the liver.

Drug Interactions

(also see **PRECAUTIONS, Drug Interactions**)

No drug interactions of clinical importance have been identified. Finasteride does not appear to affect the cytochrome P450-linked drug metabolism enzyme system. Compounds that have been tested in man have included antipyrine, digoxin, propranolol, theophylline, and warfarin, and no clinically meaningful interactions were found.

Mean (SD) Pharmacokinetic Parameters in Healthy Young Subjects (n = 15)

	Mean (\pm SD)
Bioavailability	63% (34 to 108%)*
Clearance (mL/min)	165 (55)
Volume of Distribution (L)	76 (14)
Half-Life (hours)	6.2 (2.1)
*# Range	

Mean (SD) Noncompartmental Pharmacokinetic Parameters After Multiple Doses of 5 mg/day in Older Men

	Mean (\pm SD)	
	45 to 60 years old (n = 12)	\geq 70 years old (n = 12)
AUC (ng·hr/mL)	389 (98)	463 (186)
Peak Concentration (ng/mL)	46.2 (8.7)	48.4 (14.7)
Time to Peak (hours)	1.8 (0.7)	1.8 (0.6)
Half-Life (hours)*	6.0 (1.5)	8.2 (2.5)
* First-dose values; all other parameters are last-dose values		

Clinical Studies

Finasteride 5 mg/day was initially evaluated in patients with symptoms of BPH and enlarged prostates by digital rectal examination in two 1 year, placebo-controlled, randomized, double-blind, studies and their 5 year open extensions.

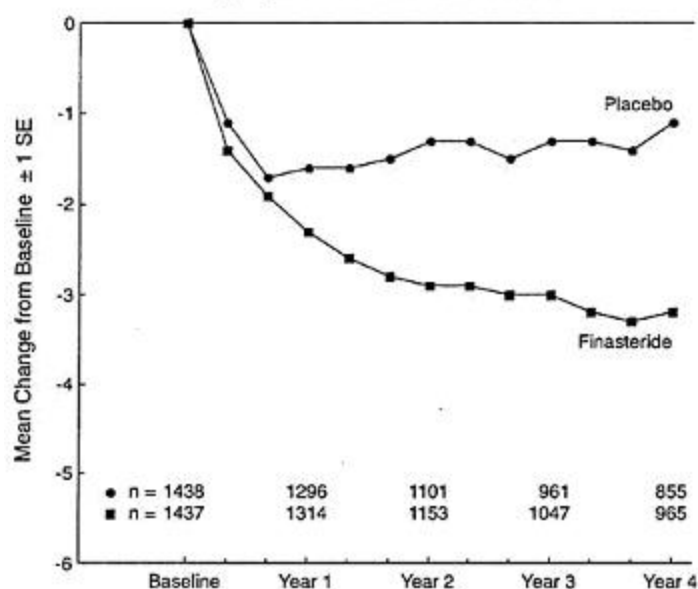
Finasteride was further evaluated in the PROSCAR Long-Term Efficacy and Safety Study (PLESS), a double-blind, randomized, placebo-controlled, 4 year multicenter study. 3040 patients between the ages of 45 and 78, with moderate to severe symptoms of BPH and an enlarged prostate upon digital rectal examination, were randomized into the study (1524 to finasteride, 1516 to placebo) and 3016 patients were evaluable for efficacy. 1883 patients completed the 4 year study (1000 in the finasteride group, 883 in the placebo group).

Effect on Symptom Score

Symptoms were quantified using a score similar to the American Urological Association Symptom Score, which evaluated both obstructive symptoms (impairment of size and force of stream, sensation of incomplete bladder emptying, delayed or interrupted urination) and irritative symptoms (nocturia, daytime frequency, need to strain or push the flow of urine) by rating on a 0 to 5 scale for six symptoms and a 0 to 4 scale for one symptom, for a total possible score of 34.

Patients in PLESS, had moderate to severe symptoms at baseline (mean of approximately 15 points on a 0 to 34 point scale). Patients randomized to finasteride who remained on therapy for 4 years had a mean (\pm 1 SD) decrease in symptom score of 3.3 (\pm 5.8) points compared with 1.3 (\pm 5.6) points in the placebo group. (See **Figure 1.**) A statistically significant improvement in symptom score was evident at 1 year in patients treated with finasteride vs. placebo (−2.3 vs. −1.6), and this improvement continued through Year 4.

Figure 1
Symptom Score in PLESS



Results seen in earlier studies were comparable to those seen in PLESS. Although an early improvement in urinary symptoms was seen in some patients, a therapeutic trial of at least 6 months was generally necessary to assess whether a beneficial response in symptom relief had been achieved. The improvement in BPH symptoms was seen during the first year and maintained throughout an additional 5 years of open extension studies.

Effect on the Need for Surgery

In PLESS, efficacy was also assessed by evaluating treatment failures. Treatment failure was prospectively defined as BPH-related urological events or clinical deterioration, lack of improvement and/or the need for alternative therapy. BPH-related urological events were defined as urological surgical intervention. Complete event information was available for 92% of the patients. The following table (**Table 1**) summarizes the results.

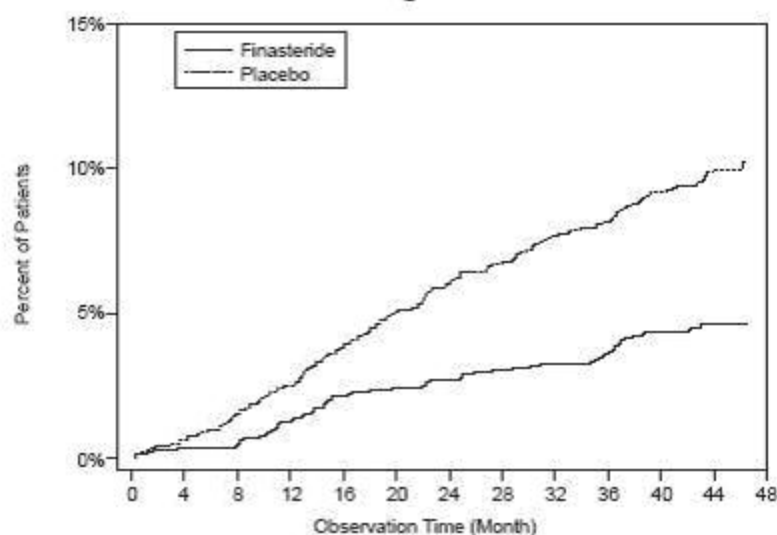
Table 1 All Treatment Failures in PLESS

Event	Patients (%) [*]		Relative Risk**	95% CI	P Value**
	Placebo N = 1503	Finasteride N = 1513			
All Treatment Failures	37.1	26.2	0.68	(0.57 to 0.79)	< 0.001
Surgical Interventions for BPH	10.1	4.6	0.45	(0.32 to 0.63)	< 0.001
Two consecutive symptom scores ≥ 20	9.2	6.7			
Bladder Stone	0.4	0.5			
Incontinence	2.1	1.7			
Renal Failure	0.5	0.6			
UTI	5.7	4.9			
Discontinuation due to worsening of BPH, lack of improvement, or to receive other medical treatment	21.8	13.3			

* patients with multiple events may be counted more than once for each type of event
 *** Hazard ratio based on log rank test

Compared with placebo, finasteride was associated with a significantly lower need for BPH-related surgery. Compared with placebo, finasteride was associated with a significantly lower risk for surgery [10.1% for placebo vs. 4.6% for finasteride; 55% reduction in risk, 95% CI: (37 to 68%)]; See **Figure 2**.

Figure 2
Percent of Patients Having Surgery for BPH, Including TURP



Placebo Group				
No. of events, cumulative	37	69	121	152
No. at risk, per year	1503	1454	1374	1314
Finasteride Group				
No. of events, cumulative	18	40	49	69
No. at risk, per year	1513	1483	1438	1410

Effect on Maximum Urinary Flow Rate

In the patients in PLESS who remained on therapy for the duration of the study and had evaluable urinary flow data, finasteride increased maximum urinary flow rate by 1.9 mL/sec compared with 0.2 mL/sec in the placebo group.

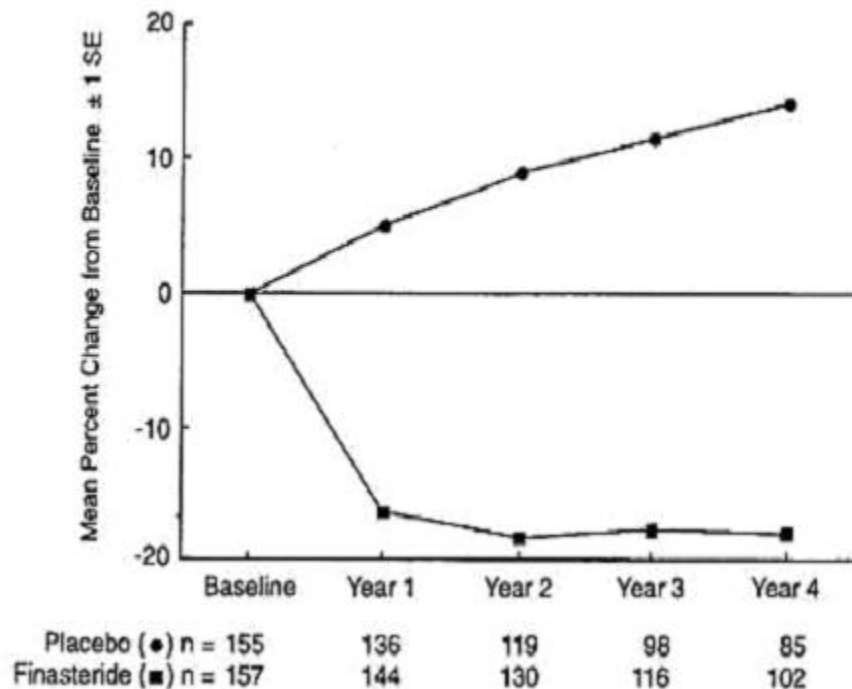
There was a clear difference between treatment groups in maximum urinary flow rate in favor of finasteride by month 4 (1.0 vs. 0.3 mL/sec) which was maintained throughout the study. In the earlier 1 year studies, increase in maximum urinary flow rate was comparable to PLESS and was maintained through the first year and throughout an additional 5 years of open extension studies.

Effect on Prostate Volume

In PLESS, prostate volume was assessed yearly by magnetic resonance imaging (MRI) in a subset of patients. In patients treated with finasteride who remained on therapy, prostate volume was reduced compared with both baseline and placebo throughout the 4 year study. Finasteride decreased prostate volume by 17.9% (from 55.9 cc at baseline to 45.8 cc at 4 years) compared with an increase of 14.1% (from 51.3 cc to 58.5 cc) in the placebo group ($p < 0.001$). (See **Figure 3**.)

Results seen in earlier studies were comparable to those seen in PLESS. Mean prostate volume at baseline ranged between 40 to 50 cc. The reduction in prostate volume was seen during the first year and maintained throughout an additional five years of open extension studies.

Figure 3
Prostate Volume in PLESS



Prostate Volume as a Predictor of Therapeutic Response

A meta-analysis combining 1 year data from seven double-blind, placebo-controlled studies of similar design, including 4491 patients with symptomatic BPH, demonstrated that, in patients treated with finasteride, the magnitude of symptom response and degree of improvement in maximum urinary flow rate were greater in patients with an enlarged prostate at baseline.

Summary of Clinical Studies

The data from these studies, showing improvement in BPH-related symptoms, reduction in treatment failure (BPH-related urological events), increased maximum urinary flow rates, and decreasing prostate volume, suggest that finasteride arrests the disease process of BPH in men with an enlarged prostate.

INDICATIONS AND USAGE

Finasteride tablets are indicated for the treatment of symptomatic benign prostatic hyperplasia (BPH) in men with an enlarged prostate to:

- Improve symptoms
- Reduce the risk of the need for surgery including transurethral resection of the prostate (TURP) and prostatectomy.

CONTRAINDICATIONS

Finasteride tablets are contraindicated in the following:
Hypersensitivity to any component of this medication.

Pregnancy

Finasteride use is contraindicated in women when they are or may potentially be pregnant. Because of the ability of Type II 5 α -reductase inhibitors to inhibit the conversion of testosterone to DHT, finasteride may cause abnormalities of the external genitalia of a male fetus of a pregnant woman who receives finasteride. If this drug is used during pregnancy, or if pregnancy occurs while taking this drug, the pregnant woman should be apprised of the potential hazard to the male fetus. (See also **WARNINGS, EXPOSURE OF WOMEN — RISK TO MALE FETUS** and **PRECAUTIONS, Information for Patients and Pregnancy**.) In female rats, low doses of finasteride administered during pregnancy have produced abnormalities of the external genitalia in male offspring.

WARNINGS

Finasteride is not indicated for use in pediatric patients (see **PRECAUTIONS, Pediatric Use**) or women (see also **WARNINGS, EXPOSURE OF WOMEN — RISK TO MALE FETUS; PRECAUTIONS, Information for Patients and Pregnancy**; and **HOW SUPPLIED**).

EXPOSURE OF WOMEN — RISK TO MALE FETUS

Women should not handle crushed or broken finasteride tablets when they are pregnant or may potentially be pregnant because of the possibility of absorption of finasteride and the subsequent potential risk to a male fetus. Finasteride tablets are coated and will prevent contact with the active ingredient during normal handling, provided that the tablets have not been broken or crushed. (See **CONTRAINDICATIONS; PRECAUTIONS, Information for Patients and Pregnancy**; and **HOW SUPPLIED**).

PRECAUTIONS

General

Prior to initiating therapy with finasteride, appropriate evaluation should be performed to identify other conditions such as infection, prostate cancer, stricture disease, hypotonic bladder or other neurogenic disorders that might mimic BPH.

Patients with large residual urinary volume and/or severely diminished urinary flow should be carefully monitored for obstructive uropathy. These patients may not be candidates for finasteride therapy.

Caution should be used in the administration of finasteride in those patients with liver function abnormalities, as finasteride is metabolized extensively in the liver.

Effects on PSA and Prostate Cancer Detection

No clinical benefit has been demonstrated in patients with prostate cancer treated with finasteride. Patients with BPH and elevated PSA were monitored in controlled clinical studies with serial PSAs and prostate biopsies. In these BPH studies, finasteride did not appear to alter the rate of prostate cancer detection. The overall incidence of prostate cancer was not significantly different in patients treated with finasteride or placebo.

Finasteride causes a decrease in serum PSA levels by approximately 50% in patients with BPH, even in the presence of prostate cancer. This decrease is predictable over the entire range of PSA values, although it may vary in individual patients. Analysis of PSA data from over 3000 patients in PLESS confirmed that in typical patients treated with finasteride for six months or more, PSA values should be doubled for comparison with normal ranges in untreated men. This adjustment preserves the sensitivity and specificity of the PSA assay and maintains its ability to detect prostate cancer.

Any sustained increases in PSA levels while on finasteride should be carefully evaluated, including consideration of non-compliance to therapy with finasteride.

Percent free PSA (free to total PSA ratio) is not significantly decreased by finasteride. The ratio of free to total PSA remains constant even under the influence of finasteride. If clinicians elect to use percent free PSA as an aid in the detection of prostate cancer in men undergoing finasteride therapy, no adjustment to its value appears necessary.

Information for Patients

Women should not handle crushed or broken finasteride tablets when they are pregnant or may potentially be pregnant because of the possibility of absorption of finasteride and the subsequent potential risk to the male fetus (see **CONTRAINDICATIONS; WARNINGS, EXPOSURE OF WOMEN — RISK TO MALE FETUS; PRECAUTIONS, Pregnancy**; and **HOW SUPPLIED**).

Physicians should inform patients that the volume of ejaculate may be decreased in some patients during treatment with finasteride. This decrease does not appear to interfere with normal sexual function. However, impotence and decreased libido may occur in patients treated with finasteride (see **ADVERSE REACTIONS**).

Physicians should instruct their patients to promptly report any changes in their breasts such as lumps, pain, or nipple discharge.

Breast changes including breast enlargement, tenderness and neoplasm have been reported (see **ADVERSE REACTIONS**).

Physicians should instruct their patients to read the patient package insert before starting therapy with finasteride and to reread it each time the prescription is renewed so that they are aware of current information for patients regarding finasteride.

Drug/Laboratory Test Interactions

In patients with BPH, finasteride has no effect on circulating levels of cortisol, estradiol, prolactin, thyroid-stimulating hormone, or thyroxine. No clinically meaningful effect was observed on the plasma lipid profile (i.e., total cholesterol, low density lipoproteins, high density lipoproteins and triglycerides) or bone mineral density. Increases of about 10% were observed in luteinizing hormone (LH) and follicle-stimulating hormone (FSH) in patients receiving finasteride, but levels remained within the normal range. In healthy volunteers, treatment with finasteride did not alter the response of LH and FSH to gonadotropin-releasing hormone indicating that the hypothalamic-pituitary-testicular axis was not affected.

Treatment with finasteride for 24 weeks to evaluate semen parameters in healthy male volunteers revealed no clinically meaningful effects on sperm concentration, mobility, morphology, or pH. A 0.6 mL (22.1%) median decrease in ejaculate volume with a

concomitant reduction in total sperm per ejaculate was observed. These parameters remained within the normal range and were reversible upon discontinuation of therapy with an average time to return to baseline of 84 weeks.

Drug Interactions

No drug interactions of clinical importance have been identified. Finasteride does not appear to affect the cytochrome P450-linked drug metabolizing enzyme system. Compounds that have been tested in man have included antipyrine, digoxin, propranolol, theophylline, and warfarin and no clinically meaningful interactions were found.

Other Concomitant Therapy

Although specific interaction studies were not performed, finasteride was concomitantly used in clinical studies with acetaminophen, acetylsalicylic acid, α -blockers, angiotensin-converting enzyme (ACE) inhibitors, analgesics, anti-convulsants, beta-adrenergic blocking agents, diuretics, calcium channel blockers, cardiac nitrates, HMG-CoA reductase inhibitors, nonsteroidal anti-inflammatory drugs (NSAIDs), benzodiazepines, H₂ antagonists and quinolone anti-infectives without evidence of clinically significant adverse interactions.

Carcinogenesis, Mutagenesis, Impairment of Fertility

No evidence of a tumorigenic effect was observed in a 24 month study in Sprague-Dawley rats receiving doses of finasteride up to 160 mg/kg/day in males and 320 mg/kg/day in females. These doses produced respective systemic exposure in rats of 111 and 274 times those observed in man receiving the recommended human dose of 5 mg/day. All exposure calculations were based on calculated AUC_(0-24 hr) for animals and mean AUC_(0-24 hr) for man (0.4 mcg•hr/mL).

In a 19 month carcinogenicity study in CD-1 mice, a statistically significant ($p \leq 0.05$) increase in the incidence of testicular Leydig cell adenomas was observed at a dose of 250 mg/kg/day (228 times the human exposure). In mice at a dose of 25 mg/kg/day (23 times the human exposure, estimated) and in rats at a dose of ≥ 40 mg/kg/day (39 times the human exposure) an increase in the incidence of Leydig cell hyperplasia was observed. A positive correlation between the proliferative changes in the Leydig cells and an increase in serum LH levels (2 to 3 fold above control) has been demonstrated in both rodent species treated with high doses of finasteride. No drug-related Leydig cell changes were seen in either rats or dogs treated with finasteride for 1 year at doses of 20 mg/kg/day and 45 mg/kg/day (30 and 350 times, respectively, the human exposure) or in mice treated for 19 months at a dose of 2.5 mg/kg/day (2.3 times the human exposure, estimated).

No evidence of mutagenicity was observed in an *in vitro* bacterial mutagenesis assay, a mammalian cell mutagenesis assay, or in an *in vitro* alkaline elution assay. In an *in vitro* chromosome aberration assay, using Chinese hamster ovary cells, there was a slight increase in chromosome aberrations. These concentrations correspond to 4000 to 5000 times the peak plasma levels in man given a total dose of 5 mg. In an *in vivo* chromosome aberration assay in mice, no treatment-related increase in chromosome aberration was observed with finasteride at the maximum tolerated dose of 250 mg/kg/day (228 times the human exposure) as determined in the carcinogenicity studies.

In sexually mature male rabbits treated with finasteride at 80 mg/kg/day (543 times the human exposure) for up to 12 weeks, no effect on fertility, sperm count, or ejaculate volume was seen. In sexually mature male rats treated with 80 mg/kg/day of finasteride (61 times the human exposure), there were no significant effects on fertility after 6 or 12 weeks of treatment; however, when treatment was continued for up to 24 or 30 weeks, there was an apparent decrease in fertility, fecundity and an associated significant decrease in the weights of the seminal vesicles and prostate. All these effects were reversible within 6 weeks of discontinuation of treatment. No drug-related effect on testes or on mating performance has been seen in rats or rabbits. This decrease in fertility in finasteride-treated rats is secondary to its effect on accessory sex organs (prostate and seminal vesicles) resulting in failure to form a seminal plug. The seminal plug is essential for normal fertility in rats and is not relevant in man.

Pregnancy

Pregnancy Category X

Finasteride is not indicated for use in women.

Administration of finasteride to pregnant rats at doses ranging from 100 mcg/kg/day to 100 mg/kg/day (1 to 1000 times the recommended human dose of 5 mg/day) resulted in dose-dependent development of hypospadias in 3.6 to 100% of male offspring. Pregnant rats produced male offspring with decreased prostatic and seminal vesicular weights, delayed preputial separation and transient nipple development when given finasteride at ≥ 30 mcg/kg/day ($\geq 3/10$ of the recommended human dose of 5 mg/day) and decreased anogenital distance when given finasteride at ≥ 3 mcg/kg/day ($\geq 3/100$ of the recommended human dose of 5 mg/day). The critical period during which these effects can be induced in male rats has been defined to be days 16 to 17 of gestation. The changes described above are expected pharmacological effects of drugs belonging to the class of Type II 5 α -reductase inhibitors and are similar to those reported in male infants with a genetic deficiency of Type II 5 α -reductase. No abnormalities were observed in female offspring exposed to any dose of finasteride *in utero*.

No developmental abnormalities have been observed in first filial generation (F₁) male or female offspring resulting from mating finasteride-treated male rats (80 mg/kg/day; 61 times the human exposure) with untreated females. Administration of finasteride at 3 mg/kg/day (30 times the recommended human dose of 5 mg/day) during the late gestation and lactation period resulted in slightly decreased fertility in F₁ male offspring. No effects were seen in female offspring. No evidence of malformations has been observed in rabbit fetuses exposed to finasteride *in utero* from days 6 to 18 of gestation at doses up to 100 mg/kg/day (1000 times the recommended human dose of 5 mg/day). However, effects on male genitalia would not be expected since the rabbits were not exposed during the critical period of genital system development.

The *in utero* effects of finasteride exposure during the period of embryonic and fetal development were evaluated in the rhesus monkey (gestation days 20 to 100), a species more predictive of human development than rats or rabbits. Intravenous administration of finasteride to pregnant monkeys at doses as high as 800 ng/day (at least 60 to 120 times the highest estimated exposure of pregnant women to finasteride from semen of men taking 5 mg/day) resulted in no abnormalities in male fetuses. In confirmation of the relevance of the rhesus model for human fetal development, oral administration of a dose of finasteride (2 mg/kg/day; 20 times the recommended human dose of 5 mg/day or approximately 1 to 2 million times the highest estimated exposure to finasteride from semen of men taking 5 mg/day) to pregnant monkeys resulted in external genital abnormalities in male fetuses. No other abnormalities were observed in male fetuses and no finasteride-related abnormalities were observed in female fetuses at any dose.

Nursing Mothers

Finasteride is not indicated for use in women.

It is not known whether finasteride is excreted in human milk.

Pediatric Use

Finasteride is not indicated for use in pediatric patients.

Safety and effectiveness in pediatric patients have not been established.

Geriatric Use

Of the total number of subjects included in PLESS, 1480 and 105 subjects were 65 and over and 75 and over, respectively. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients. No dosage adjustment is necessary in the elderly (see **CLINICAL PHARMACOLOGY, Pharmacokinetics** and **Clinical Studies**).

ADVERSE REACTIONS

Finasteride is generally well tolerated; adverse reactions usually have been mild and transient.

4 Year Placebo-Controlled Study

In PLESS, 1524 patients treated with finasteride and 1516 patients treated with placebo were evaluated for safety over a period of 4 years. The most frequently reported adverse reactions were related to sexual function. 3.7% (57 patients) treated with finasteride and 2.1% (32 patients) treated with placebo discontinued therapy as a result of adverse reactions related to sexual function, which are the most frequently reported adverse reactions.

Table 2 presents the only clinical adverse reactions considered possibly, probably or definitely drug related by the investigator, for which the incidence on finasteride was $\geq 1\%$ and greater than placebo over the 4 years of the study. In years 2 to 4 of the study, there was no significant difference between treatment groups in the incidences of impotence, decreased libido and ejaculation disorder.

TABLE 2 Drug-Related Adverse Experiences

	Year 1 (%)		Years 2, 3 and 4* (%)	
	Finasteride	Placebo	Finasteride	Placebo
Impotence	8.1	3.7	5.1	5.1
Decreased Libido	6.4	3.4	2.6	2.6
Decreased Volume of Ejaculate	3.7	0.8	1.5	0.5
Ejaculation Disorder	0.8	0.1	0.2	0.1
Breast Enlargement	0.5	0.1	1.8	1.1
Breast Tenderness	0.4	0.1	0.7	0.3
Rash	0.5	0.2	0.5	0.1
* Combined Years 2 to 4				

N = 1524 and 1516, finasteride vs. placebo, respectively

Phase III Studies and 5 Year Open Extensions

The adverse experience profile in the 1 year, placebo-controlled, Phase III studies, the 5 year open extensions, and PLESS were similar.

Long-Term Data

There is no evidence of increased adverse experiences with increased duration of treatment with finasteride. New reports of drug-related sexual adverse experiences decreased with duration of therapy.

During a 4 to 6 year placebo- and comparator-controlled study that enrolled 3047 men, there were 4 cases of breast cancer in men treated with finasteride but no cases in men not treated with finasteride. During the 4 year, placebo-controlled PLESS study that enrolled 3040 men, there were 2 cases of breast cancer in placebo-treated men, but no cases were reported in men treated with finasteride. The relationship between long-term use of finasteride and male breast neoplasia is currently unknown.

In a 7 year placebo-controlled trial that enrolled 18,882 healthy men, 9060 had prostate needle biopsy data available for analysis.

In the finasteride group, 280 (6.4%) men had prostate cancer with Gleason scores of 7 to 10 detected on needle biopsy vs. 237 (5.1%) men in the placebo group. Of the total cases of prostate cancer diagnosed in this study, approximately 98% were classified as intracapsular (stage T1 or T2). The clinical significance of these findings is unknown. This information from the literature (Thompson IM, Goodman PJ, Tangen CM, et al. The influence of Finasteride on the development of prostate cancer. *N Engl J Med* 2003; 349: 213 - 22) is provided for consideration by physicians when finasteride is used as indicated (see **INDICATIONS AND USAGE**).

Finasteride is not approved to reduce the risk of developing prostate cancer.

Postmarketing Experience

The following additional adverse effects have been reported in postmarketing experience:

- hypersensitivity reactions, including pruritus, urticaria, and swelling of the lips and face
- testicular pain.

OVERDOSAGE

Patients have received single doses of finasteride up to 400 mg and multiple doses of finasteride up to 80 mg/day for three months without adverse effects. Until further experience is obtained, no specific treatment for an overdose with finasteride can be recommended.

Significant lethality was observed in male and female mice at single oral doses of 1500 mg/m² (500 mg/kg) and in female and male rats at single oral doses of 2360 mg/m² (400 mg/kg) and 5900 mg/m² (1000 mg/kg), respectively.

DOSAGE AND ADMINISTRATION

The recommended dose is 5 mg orally once a day.

Finasteride tablets may be administered with or without meals.

No dosage adjustment is necessary for patients with renal impairment or for the elderly (see **CLINICAL PHARMACOLOGY, Pharmacokinetics**).

HOW SUPPLIED

Finasteride tablets USP, 5 mg are available as blue, film-coated, capsule-shaped tablets, debossed "93" on one side and "7355" on the other side, in bottles of 30, 90 and 100.

Storage and Handling

Store at 20° to 25°C (68° to 77°F) [See USP Controlled Room Temperature]. Protect from light and keep container tightly closed.

Women should not handle crushed or broken finasteride tablets when they are pregnant or may potentially be pregnant because of the possibility of absorption of finasteride and the subsequent potential risk to a male fetus (see **WARNINGS, EXPOSURE OF WOMEN — RISK TO MALE FETUS**, and **PRECAUTIONS, Information for Patients and Pregnancy**).

Dispense in a tight, light-resistant container as defined in the USP, with a child-resistant closure (as required).

PATIENT INFORMATION ABOUT FINASTERIDE (FIN-AS-TUR-EYED) TABLETS

Finasteride tablets are for use by men only.

Please read this leaflet before you start taking finasteride. Also, read it each time you renew your prescription, just in case anything has changed. Remember, this leaflet does not take the place of careful discussions with your doctor. You and your doctor should discuss finasteride when you start taking your medication and at regular checkups.

Why your doctor has prescribed finasteride

Your doctor has prescribed finasteride because you have a medical condition called benign prostatic hyperplasia or BPH. This occurs only in men.

What is BPH?

BPH is an enlargement of the prostate gland. After age 50, most men develop enlarged prostates. The prostate is located below the bladder. As the prostate enlarges, it may slowly restrict the flow of urine. This can lead to symptoms such as:

- a weak or interrupted urinary stream

- a feeling that you cannot empty your bladder completely
- a feeling of delay or hesitation when you start to urinate
- a need to urinate often, especially at night
- a feeling that you must urinate right away.

In some men, BPH can lead to serious problems, including urinary tract infections and the need for surgery.

Treatment options for BPH

There are three main treatment options for symptoms of BPH:

- **Program of monitoring or “Watchful Waiting”.** If a man has an enlarged prostate gland and no symptoms or if his symptoms do not bother him, he and his doctor may decide on a program of monitoring which would include regular checkups, instead of medication or surgery.
- **Medication.** Your doctor may prescribe finasteride for BPH. See “**What finasteride does**” below.
- **Surgery.** Some patients may need surgery. Your doctor can suggest several different surgical procedures for BPH. Which procedure is best depends on your symptoms and medical condition.

There are two main treatment options to reduce the risk of serious problems due to BPH:

- **Medication.** Your doctor may prescribe finasteride for BPH. See “**What finasteride does**” below.
- **Surgery.** Some patients may need surgery. Your doctor can suggest several different surgical procedures for BPH. Which procedure is best depends on your symptoms and medical condition.

What finasteride does

Finasteride lowers levels of a key hormone called DHT (dihydrotestosterone), which is a major cause of prostate growth. Lowering DHT leads to shrinkage of the enlarged prostate gland in most men. This can lead to gradual improvement in urine flow and symptoms over the next several months. Finasteride will help reduce the need for surgery. However, since each case of BPH is different, you should know that:

- Even though the prostate shrinks, you may NOT notice an improvement in urine flow or symptoms.
- You may need to take finasteride for six (6) months or more to see whether it improves your symptoms.
- Therapy with finasteride may reduce the need for surgery.

What you need to know while taking finasteride

- **You must see your doctor regularly.** While taking finasteride, you must have regular checkups. Follow your doctor's advice about when to have these checkups.
- **About side effects.** Like all prescription drugs, finasteride may cause side effects. Side effects due to finasteride may include impotence (an inability to have an erection) or less desire for sex.

Some men taking finasteride may have changes or problems with ejaculation, such as a decrease in the amount of semen released during sex. This decrease in the amount of semen does not appear to interfere with normal sexual function. In some cases these side effects went away while the patient continued to take finasteride.

In addition, some men may have breast enlargement and/or tenderness. You should promptly report to your doctor any changes in your breasts such as lumps, pain or nipple discharge. Some men have reported allergic reactions such as rash, itching, hives, and swelling of the lips and face. Rarely, testicular pain has been reported.

You should discuss side effects with your doctor before taking finasteride and anytime you think you are having a side effect.

• Checking for prostate cancer

Your doctor has prescribed finasteride for symptomatic BPH and not for cancer — but a man can have BPH and prostate cancer at the same time. Doctors usually recommend that men be checked for prostate cancer once a year when they turn 50 (or 40 if a family member has had prostate cancer). These checks should continue while you take finasteride. Finasteride is not a treatment for prostate cancer.

• About Prostate-Specific Antigen (PSA)

Your doctor may have done a blood test called PSA. Finasteride can alter PSA values. For more information, talk to your doctor.

• A warning about finasteride and pregnancy

Finasteride is for use by MEN only.

Women who are or may potentially be pregnant must not use finasteride. They should also not handle crushed or broken tablets of finasteride.

If a woman who is pregnant with a male baby absorbs the active ingredient in finasteride tablets after oral use or through the skin, it may cause the male baby to be born with abnormalities of the sex organs.

Finasteride tablets are coated and will prevent contact with the active ingredient during normal handling, provided that the tablets are not broken or crushed.

If a woman who is pregnant comes into contact with the active ingredient in finasteride tablets, a doctor should be consulted.

Remember, these warnings apply only when the woman is pregnant or could potentially be pregnant.

How to take finasteride?

Follow your doctor's advice about how to take finasteride. You must take it every day. You may take it with or between meals. To avoid forgetting to take finasteride, it may be helpful to take it at the same time every day.

Do not share finasteride with anyone else; it was prescribed only for you.

Keep finasteride and all medicines out of the reach of children.

FOR MORE INFORMATION ABOUT FINASTERIDE AND BPH, TALK WITH YOUR DOCTOR.

IN ADDITION, TALK TO YOUR PHARMACIST OR OTHER HEALTH CARE PROVIDER.

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